

REPORT ON IMPACT EVALUATION OF THE TOTAL CONTROL OF THE EPIDEMIC (TCE) PROGRAMME IN SOUTH AFRICA



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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
CBO	Community based organization
CHBC	Community home-based carer
DOH	Department of Health
DSD	Department of Social Development
EMM	Elias Motsoaledi Municipality
FGD	Focus group discussion
FO	Field Officer
GTM	Greater Tubatse Municipality
HBC	Home based care
HIV	Human immunodeficiency virus
HPP-SA	Humana People to People South Africa
HSRC	Human Sciences Research Council
KII	Key informant interview
M&E	Monitoring and evaluation
NGO	Non government organisation
OVC	Orphans and vulnerable children
PES	Perpendicular Estimate System
PHC	Primary Health Care
PLHIV	People living with HIV and/or AIDS
PMTCT	Prevention of mother to child transmission (of HIV/AIDS)
PSS	Psycho-social support
SAHA	Social Aspects of HIV/AIDS and Health Research Programme
TCE	Total Control of the Epidemic
UNAIDS	Joint United Nations Program on AIDS
VCT	Voluntary counselling and testing
WHO	World Health Organisation

EXECUTIVE SUMMARY

Humana People to People in South Africa (HPP-SA) is a section 21 non-profit company registered in 1995 in order to respond to the socio-economic needs of the underprivileged South Africans. Internationally, Humana People to People South Africa (HPP-SA) is a member of the Federation of Humana People to People found in 40 countries around the world and running over 225 projects in the areas of children's welfare and development, HIV/AIDS, Teacher Training, Farmer Training and Fundraising through the collection and sales of second hand clothes.

Total Control of the Epidemic (TCE) is one of the projects of HPP-SA. TCE is an extensive and systematic approach, whereby every single person in the community is reached with HIV/AIDS information in a person-to-person and door-to-door campaign. The idea is that only people can liberate themselves from the epidemic. In 2010, there are 20 TCE areas around the country each reaching out to 2 million people. The impact evaluation was conducted at two sites – one a TCE site (Greater Tubatse Municipality) matched with Elias Motsoaledi Municipality (EMM), also based in a cross-border area in the Limpopo province.

Evaluation design: This evaluation used a quasi-experimental, mixed quantitative-qualitative design comparing intervention and a matched control/comparison community for evaluating the TCE intervention. The quantitative study included a cross-sectional survey of 1,223 respondents in the GTM intervention community (661) and EMM comparison (562) community using a quasi-experimental community-based design. We also conducted ten interviews with key informants linked to the programme during field visits and reviewed project records to determine the impact of TCE in encouraging people to have total control of the epidemic in the intervention community.

Findings and discussion: An overwhelming majority 91.9% of respondents in the Greater Tubatse Municipality (intervention area) said that they could take control of HIV which entails having a thorough knowledge of the HI virus, knowing how to avoid being infected, and possessing the ability to decide never to get infected by HIV. This self-report implies that the majority of respondents were TCE compliant in terms of the criterion stipulated by TCE and is an endorsement that TCE had done its job in making people in GTM feel totally in control of the epidemic.

This endorsement was confirmed by another overwhelming finding. About 90.9% of respondents in the Greater Tubatse Municipality (intervention area) said they had thorough knowledge of the virus and knew how to avoid being infected with HIV. Again, 87.2% said they had decided never to get infected. TCE has done very well on these three indicators of compliance.

Although the goal of TCE was that over 65% of people who had made PES (Perpendicular Estimated System) risk reduction plans were *TCE compliant* (i.e. they had taken control), on

average, 89% of respondents in the intervention community were TCE compliant and had taken control of the epidemic. These findings showed an overwhelming proportion of respondents in the intervention community had taken control of the epidemic. This is an important finding indicating high levels of TCE compliance and that TCE had overshoot its objective of encouraging people to take control of the epidemic by about 24%.

The second objective of TCE was that over 50% of people who had been reached by Field Officers would know their HIV status, 62.3% of respondents in GTM were tested for HIV compared to 55% in EMM. In the HSRC national population-based survey of 2008, more than 52% of South Africans said they had been tested for HIV and knew their test results. The objective of 10% was too low as it has been exceeded by more than six times in GTM and by more than five times in EMM and is not aligned with national statistics of HIV testing.

More respondents in the comparison site, EMM (62.5%) compared to 59% of respondents in GTM (intervention site) said they thought they were at risk of getting HIV. This is an interesting finding and could mean that when people in GTM become compliant or in control, they avoid risky situations and see themselves less at risk of getting infected with HIV while those in EMM may feel less empowered about HIV and regard themselves at greater risk because they are not in control.

Another objective of TCE was that over 5% would be active as “passionates” or community activists¹. In this evaluation, we found that 80% of respondents from GTM said they participated actively in the TCE project. This means that sixteen times more people are actively participating in the project than was initially planned. Again, this implies that the objective of getting people to be active as passionates was set too low.

With regard to the reach of TCE, 85.3% of respondents in GTM compared to 65.3% of respondents in EMM were visited by someone to talk to them about HIV. The objective of TCE was that the programs should have reached all (100%) the households in GTM. The evaluation found that TCE fell short of its objective by 14.3%. Although this objective had not been attained in GTM, TCE had done better than all the HIV/AIDS NGOs operating in EMM who had only reached 65.3% according to the results of this evaluation.

An overwhelming 92.9% of respondents in the GTM area said TCE had made lasting changes in their lives in relation to HIV/AIDS, 94.8% said TCE campaign was accepted in the community, 94.4% said TCE was helpful to people on HIV/AIDS, 93.8% said TCE increased their resolve to know their HIV status, 94.2% said one-to-one approach helped them take total control of the epidemic and 90.2% said TCE had impact on their sexual behaviour and practice. These results are an overwhelming endorsement of the impact of TCE in the GTM community.

¹ Passionates means registered community activists

Conclusion: We conclude that TCE had impact on people in GTM taking control of the HIV epidemic. The findings show that the respondents:

- *Know all about HIV/AIDS.* They have thorough knowledge of the HIV virus, how it works and spreads and the AIDS disease.
- *Know how to avoid being infected.* They have general knowledge of sexual life, sexually transmitted diseases, the strategy for abstinence, the use of condoms, sexual abuse of children and the eventual risk for themselves for this.
- *Can decide for themselves.* Most of them have decided never to get infected by HIV and have concretely specified how to act so that it cannot possibly happen.
- *Made decisions about their first sexual encounter.* Most have decided consciously about their first sexual encounter, either to postpone it or to manage it so they do not get infected.

Recommendations: It is recommended that:

- TCE should review the objective of getting 50% of people getting tested for HIV and increase this to at least 60% of people reached by field officers.
- TCE should review the objective of getting over 5% to be community activists and should consider increasing this to at least 25%. This will confirm that empowerment has taken place and will also encourage sustainability of the project when TCE has left the community.
- The objective of reaching 100% of households be retained. It is possible that people who were not reached were new entrants in the community or are migrants who work outside the community and come now and then. However, TCE should increase its resources to ensure that all households in the community where they operate are reached.



1. INTRODUCTION

1.1. HIV and AIDS in South Africa

South Africa is experiencing an HIV/AIDS epidemic of shattering dimensions. Projections indicate that, without treatment to prevent AIDS, the number of AIDS deaths can be expected to grow within the next 10 years to more than double the number of deaths due to all other causes resulting in 5 to 7 million cumulative AIDS deaths in South Africa by 2010².

The epidemic is a development crisis, which deepens poverty and increases inequality at every level, from household to global³. Many organisations and governments have responded in many different ways to the HIV and AIDS epidemic. The responses range from biomedical HIV prevention interventions such as the administration of antiretroviral (ARV) medications, prevention of mother to child transmission (PMTCT) of HIV to behavioural prevention interventions such as condom use, encouraging people to be tested through voluntary counselling and testing (VCT), programmes to delay sexual debut, encourage fidelity and reduce multiple concurrent partnerships.

1.2. Justification for the evaluation

Humana People to People responded to the epidemic in South Africa by creating the "Total Control of the Epidemic" (TCE) program in 2000. The aim of creating TCE was to mobilize and bring the people into action, so that they can get Comparison of HIV/AIDS and help each other to deal with the consequences. The main principle of TCE is that "only the people can liberate themselves from HIV and AIDS the epidemic".

By 2010 Humana People to People in South Africa is running 11 TCE areas in 5 Provinces, employing 550 Field Officers. TCE program in Greater Tubatse Municipality was funded by Johnson and Johnson USA. By 2008, HPP had added a TCE project in the Greater Tubatse District Municipality in the Limpopo province. This project came to a close in April 2009, but many questions remained about the impact of the TCE project in all the areas where it has been implemented.

TCE has been active in South Africa since 2002, where the first TCE area was implemented in Bramfischerville in Soweto. By 2010 the program has reached 3 million people. There are questions and doubts about the impacts of ambitious interventions such as TCE. Funding

² Dorrington, R, Bourne, D, Bradshaw, D, Laubscher, R, Timaeus, I. The Impact of HIV/AIDS on Adult Mortality in South Africa. Medical Research Council. Technical Report. Burden Of Disease Research Unit. 2001:5

³ Barnett, T and Whiteside, A. Poverty and HIV/AIDS: Impact coping and mitigation policy in Cornia, G. AIDS, Public Policy and Child Well-Being", UNICEF, 2002

agencies, in particular, demand evidence that the projects that they are asked to fund, make a difference in people's lives and empower them in such a way that they are able to respond to the epidemic even when the implementers have left.

In this regard, the HSRC was commissioned by Humana People to People to conduct an impact evaluation of the TCE programme in South Africa. The impact evaluation is answering questions about the short-term effects or benefits of the TCE programme and focuses on questions such as:

- Were the objectives (as outlined on page 11) set out by the TCE programme achieved at the end of its implementation?
- What effects did the TCE programme have on recipients and the community?
- Can the effects be attributed to the programme?
- Did programme participants' knowledge, attitudes, beliefs, or behaviours change as a result of the programme?
- What happened as a result of the community outreach efforts?
- What are the effects of the community outreach efforts?

In short, this impact evaluation addresses the factors that are believed to precede, and that are linked to, longer-term outcomes.

1.3. Background on the Greater Tubatse Municipality

The Greater Tubatse Municipality is one of five local municipal areas under the Greater Sekhukhune District Municipality which is itself one of the five districts in the Limpopo Province. The other four local municipalities in the Greater Sekhukhune District Municipality are Fetakgomo, Makhuduthamaga, Groblersdal and Marble Hall. Collectively, the Greater Sekhukhune District has a population of about 967 200 according to the Statistics South Africa report of 2001. The population growth rate between 1996 and 2001 was 1.2%. This growth level is very low, thus considered insignificant in terms of planning, and is expected to remain low in the light of HIV and AIDS related deaths. The Sekhukhune District is mainly rural, with 94.7% of the total population residing in the rural areas and 5.3% in the urban areas. GTM has a population of 270,122 people.

According to the Statistics South Africa Report of 2001, the population growth rate for Sekhukhune between 1996 and 2001 was 1.2%. This growth level is very low, thus considered insignificant in terms of planning, and is expected to remain low in the light of HIV and AIDS related deaths. The Sekhukhune District is mainly rural, with 94.7% of the total population residing in the rural areas and 5.3% in the urban areas. GTM has a population of 270,122 people.

The district covers an area of about 13,235 square km with a population of about 1,055,881 people and an average population density of 87 people per square km. It is one of the poorest districts in the country, characterized by poor infrastructure and lack of safe water

supply. Some 33% of the population still depends on natural water supply and 7% have no formal means of sanitation. The unemployment rate is also high at 61.6%.

The Greater Tubatse Municipality is a cross-border municipality spread between Limpopo and Mpumalanga Provinces, situated in Limpopo. Major towns in the area are Burgersfort, Ohrigstad and Steelpoort. The economic base of the municipality is mainly in the fields of mining and agriculture. With the existence of good soil, a sub-tropical climate and the availability of reasonable quantities of water, the area boasts of a strong and prosperous farming industry which consists of fruits (citrus and grapes), vegetables (tomatoes, sweet potatoes, cabbage, peppers, beans and pumpkins), grain (wheat and maize), cotton and tobacco.

The economic centre of Greater Tubatse is the town of Burgersfort, which is also a hub of the booming Platinum mining sector. The mining activities around Burgersfort necessitated the construction of a Platinum Smelter in Polokwane. A railway line is placed between Burgersfort and Polokwane to transport the ore from the mines to the Smelter.

A small proportion of health facilities still do not have access to telephones, electricity and water. Some of the health problems that affect the district are malnutrition, diarrhoea, HIV/AIDS, STIs and TB.

In the GTM area, there are approximately 8 private medical practitioners, one private dental practitioner, 2 optometrists, 2 retail pharmacists, 239 traditional healers and 98 volunteers. About 46 NGOs and CBOs that are officially recognised by GTM appear in page 4 of this document.

In 2003, there were 43 professional nurses with 32.5 percent of posts vacant, 17 staff nurses with 41 percent of posts vacant, 17 assistant nurses with 64,7 percent of posts vacant, 19 doctors with 57,8 percent of posts vacant. The budget for primary health care (PHC) for 2000/1 was R6 413 000 and was R49 626 000 for hospitals during the same period.

Lack of communication causes major problems for nurses at the clinics when they need ambulance or emergency services for patients. In 2003, there were 21 health care facilities in GTM with 13 having functioning telephones. 5 hospitals had faxes and 13 had functioning radios while none of the health services had email access including the hospitals⁴.

Some clinics were still experiencing problems with telephone installations with the request outstanding with Telkom for more than five years. Those clinics with solar telephone system experienced problems on rainy or cloudy day with receptions, telephone become affected and transmits messages on and off. Sometimes these telephones are stopped for reasons like delayed payments and no proper accounts checking. Radiophones are mostly available but they are almost 98% out of order for the whole year. Maintenance of the radios by the

⁴ Source:

<http://www.doh.gov.za/facts/eusites/sekhukhune03.pdf#search='HIV%2FAIDS%20in%20the%20Greater%20Tubatse%20Municipality>

2. AIMS AND OBJECTIVES OF THE EVALUATION

2.1. Aim of the evaluation

The aim of the evaluation was to determine whether the project had achieved its goal of empowering people in the Greater Tubatse Municipality to attain Total Control of the Epidemic.

2.2. Objectives of the evaluation

The objectives of the evaluation were to determine whether:

- Over 65% of the people who had made use of the PES (Perpendicular Estimated System) risk reduction plan - were *TCE compliant* (i.e. they had taken control)
- Over 50% of people who had been reached by Field Officers knew their HIV status
- Over 5% were active as “*Passionates*” (community activists).
- The programs had reached all (100%) the households.

Perpendicular Estimated System (PES) is an evaluation tool used to measure the progression of people from being out of control to being in control of HIV/AIDS, and other related issues. The tool focuses on behavioural change. For a person to change his/her sexual behaviour, s/he needs to answer certain questions on the TCE PES card. The person needs to score a minimum of 85 points to qualify him/herself as TCE compliant.

2.3. Evaluation criteria

TCE was evaluated in terms of the following criteria:

1. *Efficiency*: How likely is it that *TCE program has reached all the households in the GTM*
2. *Effectiveness*: How likely is it that *over 50% of people have been mobilized to know their HIV status?*
3. *Impact*: What is the evidence that *over 65% of the people who have made a PES Plan are TCE compliant* (i.e. they have taken control of the epidemic)?
4. *Sustainability*: How likely is it that *over 5% are active as “passionates” (community activists)?*

3. METHODOLOGY

Evaluation Framework

Figure 2 below shows the framework for evaluating the TCE intervention in the Limpopo province. This framework follows six steps:

- 1) Engaging TCE stakeholders,
- 2) Describing the TCE program,
- 3) Focus the evaluation design,
- 4) Gather and analyze evidence,
- 5) Justify conclusions,
- 6) Ensure use and share lessons learned.

Figure 2: The framework for evaluating the TCE intervention



Source: Baker QE, Davis DA, Gallerani R, Sánchez V and Viadro V (2000). An Evaluation Framework for Community Health Programs. The Center for the Advancement of Community Based Public Health. Durham, North Carolina.

3.1 Engaging stakeholders

Stakeholders for this evaluation were people who care about what will be learned from the evaluation and about what will be done with the knowledge gained. These include TCE staff, TCE partners such as VCT sites and members of the community in the TCE sites.

Stakeholders were engaged very early in the evaluation so that their unique perspectives are understood. If stakeholders are not appropriately involved, evaluation findings may be ignored, criticized, or resisted.

Engaging stakeholders represented a process through which many voices were heard. The aim is to make the benefits of the evaluation clear to all stakeholders. Completing this step ensured that the focus of the evaluation - and ultimately the results of the evaluation - supported the needs of the stakeholders

Several meetings were held between the HSRC research team with Humana staff, TCE project staff, and community representatives in Gauteng (Johannesburg and Doornkop), Burgersfort (Greater Tubatse Municipality), Jane Furse (Makhuduthamaga Municipality) and Leeuwfontein (Elias Motsoaledi Municipality) to discuss how the TCE intervention was implemented and to review sites which qualified to be considered as comparison communities.

A sample of projects was visited in order to observe field examples of what the programme had delivered at community level. The field visits were carried out by HSRC researchers who engaged TCE staff and other stakeholders at project sites. Four field visits were carried out to community sites in Doornkop (in Soweto), Burgersfort (Greater Tubatse Municipality), Jane Furse (Makhuduthamaga) and Groblersdal (Elias Motsoaledi Municipality). Researchers took field notes at each of the visits and used these notes to develop the evaluation proposal.

3.2. Describing the TCE programme

As indicated in the Executive Summary, Total Control of the Epidemic (TCE) is one of the projects of HPP-SA. TCE is an extensive and systematic approach, whereby every single person in the community is reached with HIV/AIDS information in a person-to-person and door-to-door campaign based on the premise that people are the only one's who can liberate themselves from the dearth of the epidemic. In 2008, there were nine TCE areas around the country each reaching out to 900,000 people. The campaign is carried out on a daily basis by about 550 Field Officers.

The aims of the TCE project are to:

- Mobilize communities to prevent HIV and increase access to care, treatment and support programs:
- Increase HIV knowledge and promote Abstinence, Being faithful to one partner and Condom use (ABCs)
- Increase HIV testing, PMTCT, ARV & IPT programs, condom use

- Strengthen referral networks
- Meet everybody in community individually⁶

Project activities

TCE uses community volunteers to conduct several activities. These include:

- Door-to-door mobilization and person to person education, counseling and referrals to district HIV and AIDS programs.
- Adherence monitoring to treatment, using individualized risk-reduction plans.
- Workshops in schools, churches, clinics, work
- Peer educators distribute pamphlets, condoms; income generation; act as role models
- Develop volunteer base for sustainability.

The TCE program strives to reach every single person in an area of operation with information, education, mobilization, and basic counseling. The basic unit in the TCE programme is a TCE area which is a geographical area of 100,000 people including children and adult population. In such an area 50 Field Officers are recruited, trained and deployed each to a field with 2,000 people. Over three years the task of the Field Officer is to go from house to house and reach every single person on a one to one basis. On average each individual has about 3 visits in the 3 years. In Sekhukhune and for the areas under this evaluation HPP had 2 TCE areas of 200,000 people and employed a 100 Field Officers

The program provides structure and leadership which is organized like a military battle. The entire target population is referred to as a TCE area and is divided into small geographic units called fields. In each field the TCE officer together with local volunteers and development Instructors will campaign and try to mobilize the population to fight the epidemic in a variety of ways until the epidemic is under Comparison.

Each field is managed by Field Officers (FO) who are trained and supported by Division Commanders, Troop Commanders and the "special forces". A Patrol Leader has weekly leadership of 9 other Field Officers in sharing experiences. A Troop Commander has the daily leadership of 50 Field Officer, with the reporting, planning and accounting. The Division Commander leads 250 Field Officers. The task for the leadership is to ensure that Field Officers are informed, "educated", equipped, willing and mobilized to do their door to door campaigns.

The unique person-to-person approach of the program ensures that people are reached at a level that enables them to listen, and ask questions for them to thoroughly understand. During the first visit the Field Officer ensures that the people have the basic facts about HIV and AIDS. The first presentation to anyone visited by the FO is to ensure that the person has

⁶ Koppenhaver, T, Fleming, D, Meyerson, B, Robbins, A,3 Kebonang, GS, Roels, T & Kilmarx, P (2003) Exposure to a Community-Mobilization Intervention & HIV-Related Knowledge, Attitudes & Practices – Botswana.

the basic facts on HIV and AIDS and that all the myths and the misconceptions are taken care of.

TCE has developed a very comprehensive and systematic tool called the Perpendicular Estimate System - PES which can also be called a Risk Reduction Tool. It's a tool that sets up a list of demands that an individual has to work on to be in control of HIV and AIDS in their life. The demands range from the individual:-

- having the basic facts on HIV and AIDS, and other STIs
- having no myths and misconceptions,
- having tested, and being able to act according to their status,
- having to discuss and empowered to discuss status, safe sex and condoms with sexual partners,
- to being an active member of the TCE movement.

TCE uses the PES and the one on one session coupled with awareness campaigns during weekends using topics related to the cause.

The Household Register is a document for monitoring Field Officers and for monitoring the program. The Special Forces uses the Household Register to track down the performance and effectiveness of each Field Officers. All the statistics collected in TCE come from the Household Register and the analysis of these statistics go back into program development. In war rooms there are also local leaders who also assist with checking if Field Officers are signing in and out. The TCE program also has a basic baseline survey and annual surveys done by the program to measure progress or lack thereof. The survey has similar questions for the baseline and for a comparative evaluation afterwards. TCE has structures for meeting where Field Officers in groups of 10 called a Patrol and groups of 50 called a Troop meet bi-weekly to report and evaluate their work and performance.

Strategies that are used in TCE to mobilize people to know their HIV status include:

- *Door to door, person by person campaign:* Field Officers are mobilised right from initial training about the importance of knowing their HIV status. This way it gears them well for mobilising people in the door to door campaign.
- *Networking and workshops with stakeholders:* TCE Field Officers conduct workshops with nurses in the clinics and refer clients for HIV testing on a daily basis. Workshops with CBOs for support structures for those who have tested.
- *Mobile testing campaigns:* TCE staff organise mobile testing facilities with the Department of Health or other NGOs in the community and where ever they conduct community workshops, talk shows or sports tournaments.
- *Training of Field Officers and passionates:* TCE staff train their Field Officers in counselling and invite qualified nurses from Department of Health to assess whether they qualify as lay-counsellors. The Field Officers also in turn train the passionates to mobilise the community for testing.

The TRIO system

The TRIO refers to a system consisting of the individual on ARV treatment and two *Passionates*, who will monitor the individual's intake of ARV on a daily basis. The goal of a "TRIO" is to ensure that people take their medication according to the prescribed regimens. It is also designed to support the individual on treatment to deal with side effects, seek treatment of opportunistic infections, eat healthy food, get the social support and solve problems that may arise along the way.

The TRIO system is a result of the mobilization by Field Officers for people to know their HIV status. In partnership with Johnson & Johnson, TCE targets people who test HIV positive and start ARV treatment, link them up with a friend, a family member or neighbour, who will ensure that the person adheres to HIV treatment.

Collaborations and networks

Humana People to People's TCE program in Sekhukhune District was funded through a public private partnership with Johnson & Johnson USA. The Department of Health provided technical support to the TCE program.

Local leaders are seen as the cornerstone of the program and they are involved from the start of the programme. They confirm the relevance of TCE and provide the permission. They participate in the recruitment, training and launching of TCE. They continue to work with TCE throughout the three year period and they are involved in gatherings like opinion forming meetings (OFM); and meetings with the community and other stakeholders. These meetings are held to listen to their views about TCE, and consider their recommendations for improvement, so that we deliver better services to the community.

The local leaders are also recruited to work as WAR (Ward Activity Room) Leaders. A War Room is a clinic, a school, chief's house or a church where the nurse, headmaster or chief allow Field Officers to keep their attendance registers. The Field Officers sign in and out of work daily from these war rooms. The local leaders are trained as war room leaders to ask the right questions and support the Field Officers at the local level.

TCE maintains good relationships with local leaders who invite them to community gatherings to make sure that the community is fully aware of TCE and the work they do. If and when TCE staff is unable to reach a particular school during the door to door campaign, they introduce TCE to the school principals and propose to have TCE school program to that school, conducting lessons for 29 weeks on different topics.

TCE does referrals to the nearest clinics and hospitals for PMTCT, TB prevention, social services, VCT, CD4 count and STIs treatment. TCE staff also give health talks in the morning before the staff start their daily job. TCE consult with *local government* when they need geographical maps, demographic statistics of the area and other public facilities. TCE staff

has workshops with *traditional healers* to discuss the basic facts of HIV/AIDS, clearing myths and misconceptions related to HIV and AIDS and to mobilize them for VCT.

TCE staff visit *churches* on Sundays to reach people who use them since they don't find them during the week. They are sometimes allowed to conduct lessons after church services on agreement with the pastor about the topics.

TCE staff have also attached themselves with local *workplaces* where they tackle issues like discrimination, stigma and introduce the basic facts of HIV/AIDS.

When doing door to door campaign, TCE staff they come across people who are very sick. Some cannot even go to the nearest clinic. In those cases they refer them to the *home based care* and clinics.

3.3. The evaluation design

The design that the HSRC used to evaluate the programme included three key activities:

Activity 1: A cross-sectional survey of 1,200 recipients of services in the intervention and comparison communities using a quasi-experimental community-based design.

Activity 2: Ten interviews with key informants linked to the programme during field visits.

Activity 3: Review of project records such as annual reports, progress project reports, etc. This included records review to determine the impact of TCE in encouraging people to get tested for HIV in the intervention and comparison communities.

3.3.1. A quasi-experimental community-based evaluation

This evaluation used a quasi-experimental, mixed qualitative-quantitative design comparing intervention and matched Comparison community for evaluating the TCE intervention.

Greater Tubatse Municipality (GTM) was randomly selected as intervention community that implemented the intervention. It was one of the few TCE sites that had just completed implementing the intervention in 2009. GTM was compared with a comparison community (Groblersdal in Elias Motsoaledi Municipality), because both share similar characteristics. Both communities have almost similar economic and health outcomes but are far apart to prevent any possible contamination. Both sites also have the same HIV prevalence situation.

Intervention community (Greater Tubatse Municipality)

The intervention community comprises 60 villages and townships on the outskirts of Burgersfort and Steelpoort in the Greater Tubatse Municipality. The municipality has approximately 200,000 people in 29 wards. Some of the communities where the TCE intervention was implemented included:

Pelaneng	Makgemeng	Derde	Gowe	Tubatse	(
Mahlakwena	Motutulong	Gelid Tubatsana	Mohlarutse	Malwane	Plase
Mangabane	Kwa-Mototolong	Ga-Masamothane	Legapane	Ga-Mpuru	
	Mabitseng	Madiseng	Ga-Mafate		

Comparison community (Groblersdal in Elias Motsoaledi Municipality)

The demographically matched comparison community comprised 34 villages and townships on the outskirts of Groblersdal in the Elias Motsoaledi Local Municipality of Limpopo province. According to the Municipal Demarcation Board the total population of Greater Groblersdal Municipality is approximately 220,748 people compared to 218761 in 1996. The slight increase of less than 1% in population growth can be attributed to a number of reasons amongst them the migration of people to cities and areas with better job opportunities.

Design

The sample for this evaluation was selected using a **three stage cluster sampling design**.

N	X	O1
N		O2

Key:

N = no randomisation

X = TCE intervention

O1 = Intervention community (Greater Tubatse Municipality)

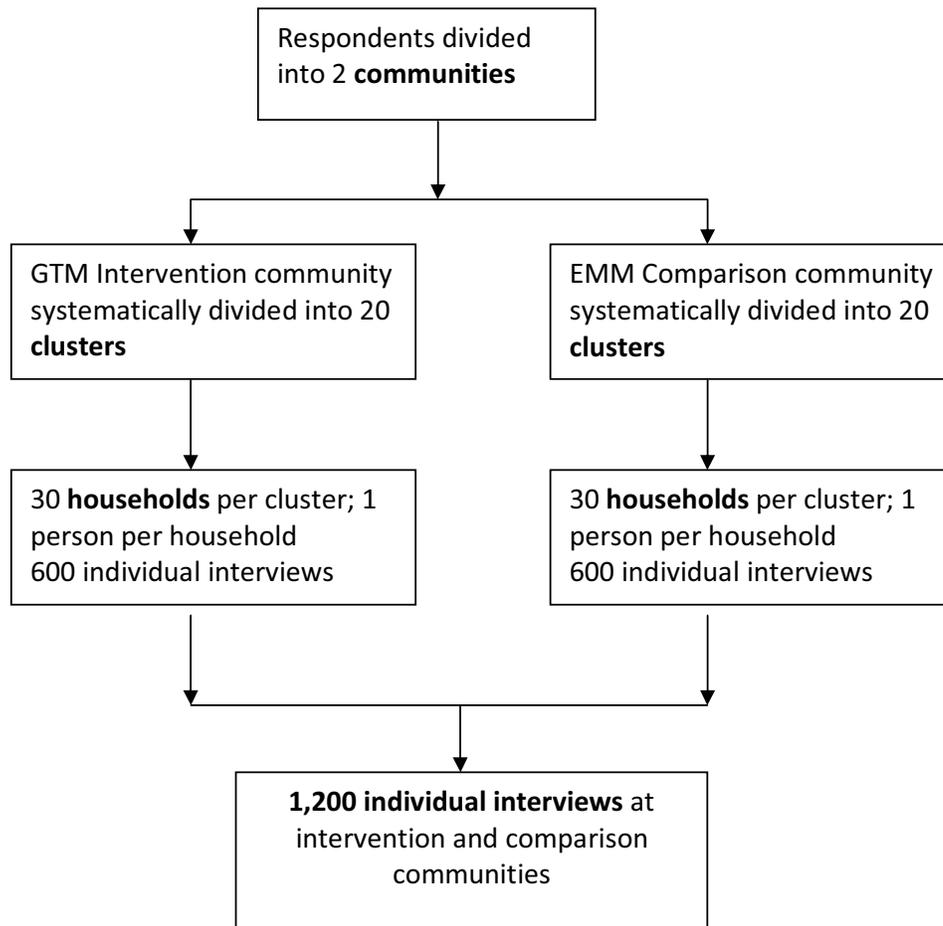
O2 = Comparison community (Groblersdal Municipality)

In stage 1, respondents were divided into two distinct communities – the intervention community in GTM (which is described above) and the comparison community.

In stage 2, the 60 communities in the GTM were systematically divided into 20 clusters while the 34 communities in Elias Motsoaledi Municipality were also systematically divided into 20 clusters.

In stage 3, 30 households were systematically sampled in each of the 20 clusters. Only one 1 person, preferably the household head, was interviewed per household. Approximately 600 individual interviews were conducted in each community or 1,200 interviews in both communities.

Figure 3: Design for the impact evaluation survey



3.4. Gather and analyze evidence

3.4.1. Questionnaire

A draft questionnaire (in Appendix C) was designed to evaluate the impact of TCE on recipients. The questionnaire focuses on:

- Exposure and reach of TCE
- Knowledge, attitudes and perception of risk
- HIV testing and mobilization of people to get tested
- Comparison and compliance issues
- Active involvement in HIV/AIDS prevention, treatment and care

3.4.2. Records review

Records review entailed the review of relevant documentation held by the TCE project office such monthly registers, quarterly and annual reports. The purpose of the review was to determine what in broad outline the programme had achieved. This included the impact of the programme using the following outputs:

- Over 65% of people reached by Field Officers were *TCE compliant* (they had taken Comparison).
- Over 50% of people were mobilized to know their HIV status.
- Over 5% are active as “*passionates*” (community activists).
- The programs had reached all households in the intervention site.

Table 1 provides a framework that was used to make an output-to-purpose evaluation against the programme's log frame. The table outlines the programme outputs, measurable indicators and the means of verification that will be used.

The HSRC among others, used several means of verification, such as reports, monitoring visits, interviews with key informants in the community.

Table 2: Evaluation of the TCE programme against the log frame

Programme Outputs	Measurable indicators	Means of verification
1. <i>Assist people to be TCE compliant</i>	1.1. No. of lessons and debates in the community on HIV/AIDS. 1.2. Number of volunteers trained in HIV/AIDS who then educate the community. 1.3. Number of volunteers trained to run HIV/AIDS education sessions. 1.4. Number of AIDS awareness campaigns that were conducted the past year. 1.5. Number of PES plans made and signed 1.6. Number of visits made	Review of 6 monthly and annual reports Interviews with key informants Household Registers and main statistics
2. <i>Mobilize individuals to know their HIV status</i>	2.1. Number of people mobilized in Greater Tubatse Municipality to get tested for HIV/AIDS. 2.2. Number of community volunteers trained on HIV/AIDS. 2.3. Number of people mobilized by TCE in the community to know HIV status.	Review of monthly registers Interviews with key informants
3. <i>Empower people to become passionates</i>	3.1. Number of people in the community trained by volunteers on HIV/AIDS. 3.2. Number of opinion forming meetings. 3.3. Number of bedridden and terminally ill patients referred to home-based care by TCE.	Review of monthly registers Interviews with key informants
4. <i>Uptake of the TCE HIV/AIDS programme in the intervention site</i>	4.1 Number of schools identified and assisted with HIV/AIDS. 4.2. Number of workplace sessions held to empower people to overcome fear and denial of HIV/AIDS. 4.3. Number of workshops with traditional healers 4.4. Number of churches reached by TCE	Review of 6 monthly reports Interviews with key informants Referrals, household registers, patrol inventory

3.4.3. Individual interviews with key programme staff

The purpose of key informant interviews was to determine whether TCE was successful in promoting HIV/AIDS programs and strengthen referral systems and linkages between individuals and communities and existing HIV/AIDS programmes.

The HSRC evaluated through KIIs the following focus areas:

1. Capacity of TCE to empower people to overcome fear, denial and stigma at all levels in the community;
2. The extent to which TCE has mobilized individuals and communities to take part in the fight against HIV and AIDS.

KIIs allowed researchers to explore in greater depth the two issues above, participant's perceptions about the problem and possible solutions. Through KIIs we were able to explore controversial or sensitive topics concerning the effectiveness of the TCE strategic and implementation plan, while offering participants the opportunity to appreciate and share ideas about their differing experiences, hiccups and possible solutions to the issues under discussion.

The HRSC conducted 10 semi-structured interviews with key informants such as representatives of clinics, local government, traditional leaders and healers, church groups and other community-based and non-governmental organizations.

Interviews were conducted telephonically, except in the case where the key informants were in close proximity to the researchers. Key informant interviews were recorded on tape in the language participants feel comfortable with and transcribed in English. An interview guide was developed with a series of open-ended questions. The discussions were led by a facilitator, and would encourage respondents to express their views.

Individual interviews were conducted using KII guide with selected members of staff, youth groups and stakeholder representatives, in particular representatives of target beneficiaries including people living with and otherwise directly affected by HIV and AIDS.

3.5. Plan for data analysis and justifying conclusions

3.5.1. Plan for analysis of survey data

Measuring exposure and reach to TCE

We defined TCE exposure and reach in 2 different ways:

1. When an individual reported having spoken to someone from TCE or participated in a discussion group.

2. When an individual lives in a health district where TCE operated. We did the district-level analysis in order to better capture community effects and the effect of TCE interventions where respondents may not have spoken with someone from TCE, for example, condom demonstrations, dramas, rallies).

Individual data: We compared respondents with TCE exposure to those without, using multivariate analysis (controlled for demographics).

Community data: We compared respondents in the intervention community (GTM) to those in the comparison community (EMM) using bivariate analysis.

Measuring TCE compliance

When an individual answered a confident yes to the statements listed below, he/she was in Comparison of HIV/AIDS and their own life and is thus TCE compliant. When all people in the community do the same, the community has achieved total Comparison of the HIV/AIDS epidemic.

A person who is TCE compliant:

- *Knows all about HIV/AIDS.* He/she has thorough knowledge of the HIV virus, how it works and spreads and the AIDS disease.
- *Knows how to avoid being infected.* He/she has general knowledge of sexual life, sexually transmitted diseases, the strategy for abstinence, the use of condoms, sexual abuse of children and the eventual risk for themselves for this.
- *Decides about themselves.* He/she has decided never to get infected by HIV and has concretely specified how to act so it cannot possibly happen.
- *First sexual encounter.* He/she has decided consciously about their first sexual encounter, either to postpone it or to manage it so they do not get infected.
- *Is part of the TCE movement.* He/she participates actively in the TCE movement, caring for the sick, helping orphans, campaigning or other activities.

Measuring the impact of TCE

Measures to analyse for the impact of the TCE intervention included:

- Increase in knowledge of HIV/AIDS
- Changes in VCT uptake and increase in people who know their HIV status
- Changes in sexual behaviour and condom use
- Changes in STI symptoms and treatment-seeking behaviour
- Changes in stigma and acceptance of people living with HIV/AIDS

3.5.2. Plan for analysis of records

Performance ratings of records review of different forms from the project were compared to indicate an assessment score. Outcome assessment scores and summary project assessment scores on efficiency, effectiveness, impact and sustainability of the programme were compared on different projects.

3.5.3. Plan for analysis of qualitative data

Qualitative data analysis methodologies were used to analyse data. The HSRC has extensive experience using these methodologies. Data obtained from key informant interviews were transcribed and analysed using content analysis. The key themes determined the extent to which the project was designed, implemented and whether it reached its intended outcomes and provided sustainable benefits and services.

Field notes taken during field visits and consultations with stakeholders were transcribed and analysed. The field notes were used to validate data obtained through key informant interviews.

3.6. Sharing lessons learned

Results of the evaluation will be shared with the parent organisation for TCE, Humana People to People and with project staff and communities in GTM and EMM at community meetings.

A poster summarising the key findings of the study has been prepared to be presented at HIV/AIDS and evaluation conferences.

4. ETHICAL CONSIDERATIONS

4.1. Risks to participants

Social risks: In order to minimise any social risks, consultations were held prior to the start of the evaluation with relevant stakeholders. The voluntary character of the evaluation and the applicability of the findings were discussed. The outcomes of these discussions were used to adjust and guide the execution of the study. All participants were given the name and telephone number of the study coordinator in case they have any question about the study or believe they had been disadvantaged or not well treated as the result of being or not being part of this survey.

Psychological risks: There was no psychological risk in participating in the study. Participants were able to refuse to answer any specific question. Also, research staff provided referrals to local services for care and treatment as appropriate. In the absence of psychologists at local health services, there were social workers who serve as professional counsellors and in some cases psychiatric nurses and lay counsellors are available to provide basic counselling services. Again, all participants were given the name and telephone number of the local study coordinator should they have any question about the study or believe they have been psychologically hurt or not well treated as the result of being or not being part of this study.

4.2 Benefits to participants

There were no direct benefits for participating in the study. Confidentiality was maintained and researchers ensured privacy during the data collection sessions.

4.3 Voluntary participation

Participants were informed that their participation in this study was strictly voluntary and that they were free to withdraw from the study at any time.

4.4 Informed consent (and assent by respondents under 18 years)

Following careful explanation of the survey, researchers gave eligible participants the consent form to read or, if necessary, the consent form was read to the participant by research staff.

All questions that arose were addressed. All participants had to verbally state that they understood and agreed to all of the items contained in the consent in order to enrol in the survey. Once the participant grants her/his consent a project staff member and participant will sign the consent form in the appropriate space.

4.5 Protection of privacy of individual

A private space was used for the interviews. The questionnaire was administered face to face with no other person in the space/room other than the interviewer and the participant.

4.6 Protection of confidential information

No names or personal identifiers were recorded on people participating in the evaluation or the key informant interviews. Signed consent forms were stored in a locked office or locked filing cabinet, separate from other study data, and there was no way of linking names on consent forms to interviews forms.



5. FINDINGS

5.1. Demographic data

The respondents lived in the Greater Tubatse (intervention) and Elias Motsoaledi (comparison) communities. Approximately 1,223 respondents participated in the survey with 661 from GTM (intervention site) and 562 from EMM (comparison site) making a ratio of 54% to 46% of the sample respectively.

About two-thirds of the respondents (66.6%) were females compared to one-third (33.4%) who were males. Although the distribution of males and females between the intervention and comparison sites was statistically significant, it was also comparable since 37.2% of males and 62.8% females were in the intervention site compared to 28.8% of males and 71.2% females from the comparison site.

An overwhelming majority of respondents were Africans (99.6%) with only 0.4% from other race groups such as Whites, Coloureds or Indians. Approximately 82.6% of respondents spoke Sepedi (Northern Sotho) as first language, followed by Setswana and isiNdebele at 4.8% respectively and 4.9% for other languages.

Only about one-quarter (24.7%) of the respondents were employed; with the majority (64%) unemployed, 6.1% were self-employed and 4.9% were students. About 7% of all respondents work for the mines and factories in the area where they live, 6.7% work as volunteer or community workers, 2.7% work in the safety, security and police sector while 2.5% work in the health and education sectors.

The respondents come from stable communities where most have lived for many years. About 29.4% have lived in their community for 11-20 years, 20.2% have lived in their community for 20 – 30 years, 28.4% have lived for 30 or more years in their community, 16.5% have lived for 1-10 years and 4.9% have lived for one year or less in the community.

Table 3: Demographic profiles of the respondents between intervention and comparison communities

	Overall		Intervention site		Comparison site		P-value
	N	%	N	%	N	%	
Total	1 223	100	661	100	562	100	
Sex of respondent							
Male	408	33.4	246	37.2	162	28.8	0.002
Female	815	66.6	415	62.8	400	71.2	
Race of respondent							
African	1,218	99.6	658	99.5	560	99.6	0.790

Report on the impact evaluation of TCE program

Others	5		3	0.5	2	0.4	
Age group							
15-24	388	31.7	217	32.8	171	30.4	
25-34	287	23.5	151	22.8	136	24.2	
35-44	204	16.7	103	15.6	101	18.0	
45-54	141	11.5	65	9.8	76	13.5	
55 & above	201	16.4	125	18.9	76	13.5	
Unspecified	2	0.2	0.0	0.0	2	1.4	0.021
Language of respondent							
Sepedi	1,009	82.6	603	91.4	406	72.2	
Setswana	58	4.8	4	0.6	54	9.6	
isiNdebele	58	4.8	3	0.5	55	9.8	
Other	97	7.9	50	7.6	47	8.4	0.000
Employment status							
Employed	302	24.7	169	25.6	133	23.7	
Unemployed	783	64	437	66.1	346	61.6	
Self-employed	75	6.1	35	5.3	40	7.1	
Scholar/student	60	4.9	20	3.0	40	7.1	
Other	3	0.3	0.0	0.0	3	0.5	0.002
Employer							
Government	21	1.7	14	2.2	7	1.3	
Mines and factories	85	7.0	69	10.4	16	2.9	
Agriculture and farming	20	1.6	10	1.5	10	1.8	
Housing and building industry	11	0.9	6	0.9	5	0.9	
Safety, security and police	33	2.7	16	2.4	17	3.0	
Roads and works	8	0.7	2	0.3	6	1.1	
Driver of public transport	8	0.7	6	0.9	2	0.4	
Volunteer or community worker	82	6.7	35	5.3	47	8.4	
Health and education	30	2.5	17	2.6	13	2.3	
Not applicable	787	64.5	447	67.6	340	60.7	
Other	136	11.1	39	5.9	97	17.3	0.000

Period lived in community							
Less than a year	60	4.9	40	6.1	20	3.6	
1-10 years	203	16.5	110	16.7	92	16.0	
11-20 years	259	29.4	176	26.6	183	32.5	
20-30yrs	247	20.2	124	18.8	123	21.9	
More than 30 years	347	28.4	203	30.7	144	25.6	
Other	8	0.7	8	1.2	0.0	0.0	0.0039

5.2. TCE compliance

TCE compliance meant that an individual felt that they were in control of the epidemic, which meant having thorough knowledge of HIV transmission, prevention and treatment and its progression to AIDS; knowing how to avoid infection by the HI virus and deciding to protect oneself from getting infected. An overwhelming majority, 91.9%, of respondents in the Greater Tubatse Municipality (intervention area) agreed that they were in control of the epidemic according to this definition. This implies that the majority of respondents were TCE compliant.

Table 3: Have they taken control of HIV/AIDS?

I can take control of HIV	N	%
Yes	607	91.9
No	54	8.2

With regard to knowledge about HIV/AIDS, 93.5% (GTM) vs. 90.6% (EMM) of respondents said they have thorough knowledge of the virus and slightly more respondents 93.6%, from GTM said they knew how to avoid being infected with HIV compared with 90.9% from EMM. With regard to their attitudes towards HIV/AIDS fewer respondents from GTM, 84.5% said they had decided never to get infected with HIV compared with 87.2% from EMM. There was a significant difference (p-value 0.002) on knowledge of how to avoid being infected with HIV among respondents from GTM compared to respondents from EMM (comparison community).

Table 4: Knowledge and attitudes towards HIV/AIDS

	Intervention site		Comparison site		P-value
	N	%	N	%	
Have thorough knowledge of virus					
Yes	618	93.5	511	90.9	
No	43	6.5	51	9.1	0.093

Know how to avoid being infected with HIV					
Yes	410	90.7	250	83.1	
No	42	9.3	51	16.9	0.002
Decided never to get infected					
Yes	558	84.6	490	87.2	
No	102	15.5	72	12.8	0.188

5.3. People are mobilized to know their HIV status

An overwhelming majority of respondents in the GTM intervention community 89.8% said that mobilization by TCE Field Officers had significant impact on them getting tested for HIV. About 60.6% agreed that mobilization by TCE Field Officers had significant impact on them getting tested for HIV, followed by those who strongly agreed with this statement at 29.2%.

Table 5: Impact of mobilization by TCE Field Officers on people who got tested for HIV

	Intervention site	
	N	%
Mobilization by TCE Field Officers had significant impact on the people who got tested for HIV		
Strongly agree	193	29.2
Agree	400	60.6
Disagree	60	9.1
Strongly disagree	7	1.1

Table 6 shows that 80.3% of the respondents in GTM got someone to talk to them about HIV and 62.3% were tested for HIV compared to 69.8% in EMM who got someone to talk to them about HIV and only 55% of them were tested.

The results show that the excess number of respondents in GTM (10.5%) was reached by community volunteers from TCE with information on HIV testing and only 7.3% more got tested in GTM than in EMM. This is not statistically significant.

When respondents were asked how long ago they had their most recent HIV test, 47.9% in GTM vs. 59.2% in EMM said it was less than a year ago and 35.5% in GTM vs. 22.3% in EMM said it was 1-2 years ago. Overall, this means that slightly more respondents 83.4% in GTM vs. 81.5% in EMM had their most recent HIV test in the last two years. The finding that more respondents in EMM had their most recent test less than a year ago than in GTM was statistically significant ($p < 0.002$). The possible explanation for this is that TCE had withdrawn its services from GTM a year preceding the evaluation while the NGOs in EMM were warming up to the national campaign to mobilize people to get tested. It is not

surprising that 13.2% more people had been tested in GTM than in the last 1-2 years than in EMM because TCE was on site 1-2 years earlier.

An interesting finding was that more respondents in EMM 97.1% vs. 87.6% in said they had been informed of their most recent HIV test results. It is most probable that respondents in GTM were not following up on their HIV test results because most of them did not perceive themselves at greater risk of getting infected with HIV as compared to respondents in EMM.

While most of the respondents from GTM (58%) were motivated to test for HIV by a community volunteer from TCE, majority respondents from EMM (38.2%) were motivated to test for HIV by a doctor from the clinic or public hospital, followed by volunteers from local NGO's (33%).

Table 6: Information about HIV testing and getting tested

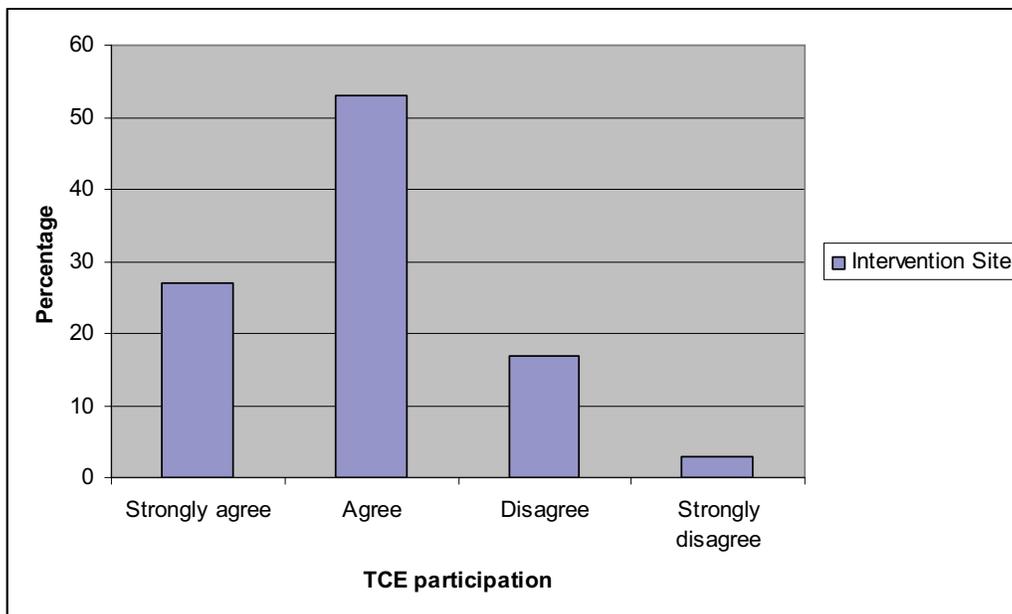
Did anyone talk to you about getting tested for HIV	Intervention site		Comparison site		P-value
	N	%	N	%	
Yes	531	80.3	392	69.8	0.000
No	130	19.7	170	30.2	
Ever tested for HIV					
Yes	411	62.3	309	55.0	0.013
No	239	36.1	248	44.1	
No response	11	1.7	5	0.9	
How long ago did you have your most recent HIV test					
Less than a year ago	197	47.9	183	59.2	0.002
1-2 years	146	35.5	69	22.3	
2-3 years	38	9.2	29	9.4	
3-4 years	11	2.7	15	4.9	
4-5 years	4	1.0	6	1.9	
5 years and above	15	3.6	6	1.9	
Not applicable	0.0	0.0	1	0.3	
Have been informed of most recent HIV test results					
Yes	360	87.6	300	97.1	0.0001
No	46	11.2	9	2.9	
Not applicable	4	1.0	0.0	0.0	

Motivation to test for HIV					
Community volunteer from TCE	238	58.0	12	3.9	
Volunteer from local NGO	65	15.9	102	33.0	
Community worker linked to government project	23	5.6	10	3.2	
Doctor from a clinic or public hospital	35	8.5	118	38.2	
Doctor from private clinic or hospital	13	3.2	19	6.1	
Traditional healer	1	0.2	0.0	0.0	
Other	25	6.1	48	15.5	
Not applicable	10	2.4	0.0	0.0	0.000

5.4. People who are active as “passionates” (community activists)

Approximately 80% of respondents from GTM said they participated actively in the TCE project. As a result of TCE interventions in GTM, there were people who became community activists (“passionates”) and Figure 4 (below) shows that majority (53.1%) of the people agreed to participate actively in the TCE, followed by those who strongly agreed at 26.9%. Only about 20% of respondents in GTM said that they did not participate actively in TCE activities.

Figure 4: Participation in TCE activities in Greater Tubatse Municipality



5.5. Programme reach in households in GTM and EMM

Approximately 85.3% of respondents in GTM compared to 65.3% of respondents in EMM were visited by someone to talk to them about HIV. Although the difference is 20%, it is not statistically significant. When asked which organization visited them, 60.8% in GTM and 0.5% in EMM said they were visited by TCE. This was an unexpected finding as no visits had been expected to have taken place in EMM by TCE. A likely explanation to this is that the respondents had been in GTM during the TCE intervention period and had travelled back to EMM by the time the evaluation was conducted. Another possible explanation is that there may have been misunderstandings as to what was asked and hence the unexpected outcome. Majority of respondents in EMM (54.8%) as compared to 17.1% in GTM were visited by a local NGO either than TCE.

When asked who visited them to talk about HIV, 58.2% in GTM compared to 1.8% from EMM said they were visited by a community volunteer from TCE, again, no respondents were expected to have been visited by a TCE volunteer in EMM and the mobility of people probably accounts for this. However, 45.1% of respondents from EMM compared to 16.6% from GTM said they were visited by a volunteer from the local NGO.

A majority of respondents from GTM (53.7%) compared to 33.8% in EMM were visited at home. This implies that the home visits conducted by TCE made the difference between the two sites.

Table 7: Reach of HIV programmes to households in GTM and EMM

	Intervention site		Comparison site		P-Value
	N	%	N	%	
Ever visited to talk about HIV					
Yes	564	85.3	367	65.3	
No	90	13.6	191	34.0	
Don't know	7	1.1	4	0.7	0.00
Organization visited					
TCE	402	60.8	3	0.5	
Local NGO	113	17.1	308	54.8	
Governmental official	45	6.8	57	10.1	
Other	28	4.2	14	2.5	
Not applicable	73	11.0	180	32.0	0.00
Who visited you					
Community volunteer from TCE	385	58.2	10	1.8	
Volunteer from local NGO	110	16.6	304	54.1	
Community worker linked to government project	42	6.4	41	7.3	
Other	49	7.4	28	5.0	
	75	11.3	179	31.9	0.00

Where the respondent was visited					
School	159	24.1	133	23.7	
Work	38	5.7	41	7.3	
Church	9	1.4	7	1.2	
Home	355	53.7	190	33.8	
Other	32	4.8	13	2.3	
Not applicable	68	10.3	178	31.7	0.00

5.6. Impact of HIV programmes on behaviour change

Almost the same ratio of respondents in the GTM community (81.5%) and 81.9% in the EMM community said they had decided about their first sexual encounter, how to manage sexual relations or postponing sexual debut. This implies that TCE did not have impact on behaviour change in the community where it operated.

Table 8: Impact of HIV programmes on behaviour change

Decided about first sexual encounter Managing sexual relations or Postponing sexual debut	Intervention site		Comparison site		P-value
	N	%	N	%	
Yes	539	81.5	460	81.9	0.8898
No	122	18.5	102	18.1	

More respondents in the comparison site, EMM (62.5%) compared to 59% of respondents in GTM (intervention site) said they thought they were at risk of getting HIV. Perception of risk of getting infected with HIV has impact on behaviour change. People have higher perception of risk when their knowledge levels of HIV are lower (like in EMM) and the opposite is true.

Table 9: Perception of risk of getting HIV

	Intervention site		Comparison site		P-Value
	N	%	N	%	
Think they are at risk of getting HIV	390	59.0	351	62.5	
Think they are not at risk of getting HIV	200	30.3	149	26.5	
Don't know if they are at risk of getting HIV	71	10.7	62	11.0	0.35

5.7. Impact of TCE on the community

Approximately 92.9% of respondents in the GTM area said TCE had made lasting changes in their lives in relation to HIV/AIDS, 94.8% said TCE campaign was accepted in the community, 94.4% said TCE was helpful to people on HIV/AIDS matters, 93.8% said TCE increased their resolve to know their HIV status, 94.2% said one-to-one approach helped them take total control of the epidemic and 90.2% said TCE had impact on their sexual behaviour and practice.

These results are an overwhelming endorsement of the impact of TCE in the GTM community.

Table 10: Impact of TCE on the community

	Intervention site	
	N	%
TCE has made lasting changes in my life in relation to HIV/AIDS		
Strongly agree	190	28.8
Agree	423	64.1
Disagree	40	6.1
Strongly disagree	7	1.1
TCE campaign was accepted in the community		
Strongly agree	240	36.3
Agree	387	58.5
Disagree	27	4.1
Strongly disagree	7	1.1
TCE was helpful to people on HIV/AIDS matters		
Strongly agree	239	36.2
Agree	385	58.2
Disagree	30	4.5
Strongly disagree	7	1.1
TCE increased our resolve to know our HIV status		
Strongly agree	232	35.1
Agree	388	58.7
Disagree	34	5.1
Strongly disagree	7	1.1
One-to-one approach helped us take total control of the epidemic		
Strongly agree	209	31.6
Agree	414	62.6
Disagree	31	4.7
Strongly disagree	7	1.1

TCE had impact on my sexual behaviour and practice		
Strongly agree	220	33.3
Agree	376	56.9
Disagree	60	9.1
Strongly disagree	5	0.8

Attitudes of community members towards PLHIV

About 92.1% of respondents in the GTM community compared to 87.2% in the EMM community said they were willing to care for family member with AIDS. An equal proportion of respondents in both communities (92.6 vs. 92.5%) said they would be willing to shake hands or hug a person living with HIV, 90.8% vs. 87.9% said they were willing to eat a meal prepared by an HIV positive person and 90.2% vs. 93.8% said they were willing to spend time with an HIV positive person.

Table 11: Attitudes of community members to PLHIV

	Intervention site		Comparison site		P-Value
	N	%	N	%	
Would be willing to care for family member with AIDS					
Yes	609	92.1	490	87.2	0.014
No	37	5.6	55	9.8	
Don't know	15	2.3	17	3.0	
Willing to shake hands or hug PLWHIV					
Yes	612	92.6	520	92.5	0.878
No	35	5.3	32	5.7	
Don't know	14	2.1	10	1.8	
Willing to eat meal prepared HIV+ person					
Yes	600	90.8	493	87.9	0.077
No	51	7.7	49	8.7	
Don't know	9	1.4	19	3.4	
Willing to spend time with HIV+ person					
Refuse to answer	10	1.5	2	0.4	0.084
Yes	596	90.2	525	93.4	
No	44	6.7	26	4.6	
Don't know	11	1.7	9	1.6	

HIV/AIDS communication among community members

There was no difference between the two sites with respect to talking about HIV with friends, knowing of anyone who died from AIDS and knowing of someone living with HIV. Approximately 77% of respondents in the GTM compared to 77.2% in the EMM community said they had talked about HIV with friends, 41% vs. 42.7% of respondents said that they knew of anyone who died from AIDS and 43.3% vs. 44% of respondents said they knew of someone living with HIV.

Table 12: Communicating about HIV/AIDS among community members

	Intervention site		Comparison site		P-Value
	N	%	N	%	
Talked about HIV with friends					
Yes	509	77.0	434	77.2	
No	145	21.9	127	22.6	
Don't know	7	1.1	1	0.2	0.154
Know of anyone died from AIDS					
Yes	271	41.0	240	42.7	
No	346	52.3	300	53.4	
Don't know	44	6.7	22	3.9	0.098
Know of someone living with HIV					
Yes	286	43.3	247	44.0	
No	302	45.7	282	50.3	
Don't know	73	11.0	32	5.7	0.004

6. DISCUSSION

An overwhelming majority 91.9% of respondents in the Greater Tubatse Municipality (intervention area) said that they could take control of HIV. This self-report implies that the majority of respondents were TCE compliant and is an endorsement that TCE had done its job in making people in GTM to feel totally in control of the epidemic.

This endorsement was confirmed by another overwhelming finding. About 90.9% of respondents in the Greater Tubatse Municipality (intervention area) said they had thorough knowledge of the virus and knew how to avoid being infected with HIV. Again, 87.2% said they had decided never to get infected. TCE has done very well on these three indicators of compliance.

Although the goal of TCE was that over 65% of people who had made PES (Perpendicular Estimated System) risk reduction plans were *TCE compliant* (i.e. they had taken control), on average, 89% of respondents in the intervention community were TCE compliant and had taken control of the epidemic. These findings showed an overwhelming proportion of respondents in the intervention community had taken control of the epidemic. This is an important finding indicating high levels of TCE compliance and that TCE had overshot its objective of encouraging people to take control of the epidemic by about 24%.

Although the objective of TCE was that over 50% of people who had been reached by Field Officers would know their HIV status, 89.8% said that mobilization by TCE Field Officers had significant impact on them getting tested for HIV. About 62.3% of respondents in GTM were tested for HIV compared to 55% in EMM. In the HSRC national population-based survey of 2008, more than 52% of South Africans said they had been tested for HIV and knew their test results. The objective of 50% was reasonable but had been exceeded by 12% in GTM and by 5% in EMM.

More respondents in the comparison site, EMM (62.5%) compared to 59% of respondents in GTM (intervention site) said they thought they were at risk of getting HIV. This was an interesting finding and could mean that when people in GTM became compliant or in control, they avoided risky situations and saw themselves less at risk of getting infected with HIV while those in EMM may have felt less empowered about HIV and regarded themselves at greater risk because they were not in control.

The objective of TCE was that over 5% would be active as “passionates” or community activists. In this evaluation, we found that 80% of respondents from GTM said they participated actively in the TCE project. This means that sixteen times more people are actively participating in the project than was initially planned. Again, this implies that the objective of getting people to be active as passionates was set too low.

With regard to the reach of TCE, 85.3% of respondents in GTM compared to 65.3% of respondents in EMM were visited by someone to talk to them about HIV. The objective of TCE was that the programs should have reached all (100%) the households in GTM. The evaluation found that TCE fell short of its objective by 14.3%. Although this objective had not been attained in GTM, TCE had done better than all the HIV/AIDS NGOs operating in EMM who had only reached 65.3%. There is a likelihood that some of the 14.3% who were not reached by Field Officers were either not at home when TCE came; or another family member was reached and decided not to share with the family member who was interviewed for the evaluation.

About 92.9% of respondents in the GTM area said TCE had made lasting changes in their lives in relation to HIV/AIDS, 94.8% said TCE campaign was accepted in the community, 94.4% said TCE was helpful to people on HIV/AIDS, 93.8% said TCE increased their resolve to know their HIV status, 94.2% said one-to-one approach helped them take total control of the epidemic and 90.2% said TCE had impact on their sexual behaviour and practice. These results are an overwhelming endorsement of the impact of TCE in the GTM community.

Table 13 provides a summary of the evaluation of impact of the TCE project in Greater Tubatse Municipality. TCE obtains a very good overall rating for its achievements. TCE exceeded 3 of the four objectives it had set. These are increasing TCE compliance, mobilizing people to know their HIV status and encouraging people to become passionates or community activists.

Table 13: Summary evaluation of impact

Major objectives	Targets (milestones)	Achieved	Rating of achievements (0-4)	Factors explaining over/under achievement
TCE compliance (they have control)	65%	89%	4	Most FO are young
People are mobilized know their HIV status	50%	62.3%	4	PES approach works
"Passionates" (community activists)	5%	80%	4	Opportunity to be part of the fight
The programs have reached all households	100%	85.3%	3	Household approach seems to work

There were no significant differences in behaviour change in the two sites as almost the same ratio of respondents in the GTM community (81.6%) and 81.9% in the EMM community said they had decided about their first sexual encounter, management or postponing sexual debut. This implies that TCE did not have make significant difference on behaviour change in the community where it operated.

Overall, there were no significant differences in attitudes of community members towards PLHIV. About 92.1% of respondents in the GTM community compared to 87.2% in the EMM community said they were willing to care for family member with AIDS. An equal proportion of respondents in both communities (92.6 vs. 92.5%) said they would be willing to shake hands or hug a person living with HIV, 90.8% vs. 87.9% said they were willing to eat a meal prepared by an HIV positive person and 90.2% v.s.93.8% said they were willing to spend time with an HIV positive person.

Again, there was no difference between the two sites with respect to communicating about HIV with friends, knowing of anyone who died from AIDS and knowing of someone living with HIV. This implies that although TCE assisted people in GTM to be in control of the epidemic, it however, did not have impact on them with respect to communicating about HIV with friends.

Another goal of TCE was to increase the uptake of district programs like VCT, PMTCT, ARVT and the use of condoms. It has been shown above that the uptake of VCT has increased due to HIV.



Limitations of the study

The ideal form of measuring the impact of a program such as TCE is to determine HIV incidence. This could be done by testing, for example through dried blood spots (DBS), people sampled for the survey in the intervention and comparison communities. The alternative is to obtain the results of HIV incidence for both communities from the national population survey. Unfortunately, the national population survey of 2008 had not yet published the HIV incidence report and the HIV prevalence was not disaggregated by health district to be able to model or extrapolate HIV incidence for both communities. In the absence of district incidence and/or prevalence data, it was difficult to determine the true impact of TCE in the Greater Tubatse Municipality.

There is no accepted quality-scoring tool for quasi-experimental evaluations such as this one. Possible limitations include: 1) the cross-sectional sample will make it difficult to assess the durability of the program's effect for people once they leave the community; 2) the reliance on self-reported outcome measures may introduce bias; and 3) there is no blinding. Additionally, exposure to a household intervention such as TCE is coincident with being available at home, thus limiting the interpretation of exposure effects.

Although the comparison community (EMM) was about 200 km away from the intervention community, it is possible that contamination would have occurred. There are many NGOs and CBOs in the comparison community who may have learned and adopted some elements of the approach used by TCE, and some respondents may have been in the intervention site for work or visiting while the intervention was underway and thus limit the power of the evaluation in having a completely uncontaminated comparison community. Others may have learned the approach at workshops, from pamphlets, on the internet or even on the TCE website. Therefore although all measures had been taken to ensure that the comparison community had never heard of TCE, due to the nature of the study these measures could not be controlled completely.



7. CONCLUSION AND RECOMMENDATIONS

An overwhelming majority of people in the Greater Tubatse Municipality (intervention area) have taken control of the HIV epidemic and most of them are TCE compliant. TCE has done a good job in making people in GTM to feel totally in control of the epidemic.

TCE has done very well in reaching a large majority of people that they had wanted to reach in the in GTM. Eventhough, they fell short of their objective by 14.3%, they had invested lots of resources and had done well in their house-to-house campaigns.

We conclude that TCE had impact on people in GTM taking control of the HIV epidemic. The findings show that the respondents:

- *Know all about HIV/AIDS.* They have thorough knowledge of the HIV virus, how it works and spreads and the AIDS disease.
- *Know how to avoid being infected.* They have general knowledge of sexual life, sexually transmitted diseases, the strategy for abstinence, the use of condoms, sexual abuse of children and the eventual risk for themselves for this.
- *Can decide for themselves.* Most of them have decided never to get infected by HIV and have concretely specified how to act so that it cannot possibly happen.
- *Made decisions about their first sexual encounter.* Most have decided consciously about their first sexual encounter, either to postpone it or to manage it so they do not get infected.

Six times more people got tested from HIV in the intervention area due to the work of field officers. This is a great achievement as The Presidency and the South African National AIDS Council (SANAC) are making preparations to launch a national HIV testing and know your status campaign. TCE has prepare the ground in GTM for the “safe landing” of the national HIV testing campaign.

The objective of getting 50% of people who had been reached by Field Officers, getting tested for HIV was reasonable but was exceeded by 12% in GTM and by 5% in EMM. This goal was comparable to the HSRC national population-based survey of 2008, where more than 52% of South Africans said they had been tested for HIV and knew their test results.

It is recommended that TCE should review the objective of getting 50% of people getting tested for HIV and increase this to at least 60% of people reached by field officers.

The objective of TCE was that over 5% would be active as “*passionates*” or community activists while 80% of respondents from GTM said they participated actively in the TCE project. This means that sixteen times more people were actively participating in the project than was initially planned. Again, this implies that the objective of getting people to be active as *passionates* was set too low.

It is recommended that TCE should review the objective of getting over 5% to be community activists and should consider increasing this to at least 25%. This will confirm that empowerment has taken place and will also encourage sustainability of the project when TCE has left the community.

It is recommended that the objective of reaching 100% of households be retained. It is possible that people who were not reached were new entrants in the community or are migrants who work outside the community and come now and then. However, TCE should increase its resources to ensure that all households in the community where they operate are reached.



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APPENDICES

APPENDIX A: QUESTIONNAIRE FOR EVALUATING THE IMPACT OF TCE

A. DEMOGRAPHIC DATA

Site where survey is conducted

- | |
|---|
| 1 = Greater Tubatse Municipality |
| 2 = Greater Groblersdal Municipality |

I am first going to ask you some general questions about yourself.

1. Sex (your gender)

- | |
|------------|
| 1 = Male |
| 2 = Female |

2. Race (your race)

- | |
|--------------|
| 1 = African |
| 2 = White |
| 3 = Coloured |
| 4 = Indian |
| 9 = Other |

3. How old are you? (Age in years)

4. What is your tribal affiliation?

- 1 = English
- 2 = Afrikaner
- 3 = Ndebele
- 4 = Mopedi
- 5 = Motswana
- 6 = Venda
- 7 = Tsonga

- 8 = Swati
- 9 = Xhosa
- 10 = Zulu
- 11 = Mosotho

5. What is your home language? (The language that you speak most often at home)

- 01 = English
- 02 = Afrikaans
- 03 = isiNdebele
- 04 = sePedi
- 05 = seTswana
- 06 = tshiVenda
- 07 = xiTsonga
- 08 = siSwati
- 09 = isiXhosa
- 10 = isiZulu
- 11 = seSotho sa borwa
- 99 = Other (specify):

6. What is your employment status

1 = Employed
2 = Unemployed
3 = Self-employed

7. If you are employed, who do you work for?

1 = Provincial Government
2 = Mines
3 = Factories
4 = Local Government
5 = Agriculture and farming
6 = Housing and building industry
7 = Safety, security and police
8 = Roads and Works
9 = Driver of public transport,
10 = Volunteer or community worker
11 = Health
12 = Education
99 = Other (specify):

8. How long have you lived in this community?

1 = Less than 1 year
2 = 1 – 5 years

3 = 6 – 10 years
4 = 11 – 15 years
5 = 16 – 20 years
6 = 20 – 30 years
7 = More than 30 years

B. EXPOSURE AND REACH OF TCE

I am going to ask you are about the HIV and AIDS programmes you have been exposed to and people who have talked to you about HIV/AIDS.

9. Has anyone from ever visited you to talk to you about HIV or AIDS?

1 = Yes (Go to questions 10-12)
2 = No (Go to question 13)
9 = Don't know

10. If Yes, which organization visited you to talk to you about HIV or AIDS?

1 = Total Comparison of the Epidemic (TCE) or those who were red T-shirt
2 = Local NGO
3 = Government official
4 = Other (specify)

11. Who visited you and spoke to you about HIV or AIDS

1 = Community volunteer from TCE
2 = Volunteer from the Local NGO
3 = Community worker linked to a Government project
4 = Other (specify)

12. Where did they visit you?

1 = Home
2 = Work
3 = Church
4 = School
5 = Other (specify)

C. KNOWLEDGE, ATTITUDES AND PERCEPTION OF HIV RISK

The next questions I am going to ask you are about the impact that HIV and AIDS have had on your life.

13. Have you talked about HIV or AIDS with any of your friends or neighbours?

1 = Yes
2 = No
9 = Don't know

14. Do you know anyone who has died of AIDS in your family or community?

1 = Yes
2 = No
9 = Don't know

15. Do you know anyone who is living with HIV or AIDS in your family or community?

1 = Yes
2 = No
9 = Don't know

The next questions ask your opinions about how you see the problem of HIV and AIDS. Please say what you think. There are no right or wrong answers.

16. Do you think that you are at risk of getting HIV or AIDS?

1 = Yes
2 = No
9 = Don't know

17. Would you be willing to care for a family member with AIDS?

1 = Yes
2 = No
9 = Don't know

18. Would you be willing to shake hands or hug a person with HIV or AIDS?

1 = Yes
2 = No
9 = Don't know

19. Would you be willing to eat a meal prepared by someone who had HIV or AIDS?

1 = Yes
2 = No
9 = Don't know

20. Would you be willing to spend time with a friend or neighbour who has HIV or AIDS?

1 = Yes

2 = No
9 = Don't know

C. HIV TESTING AND MOBILISATION OF PEOPLE TO GET TESTED

The next questions ask your opinions about HIV testing and whether people have been impacted to get tested

21 Did anyone talk to you about getting tested for HIV?

Yes	No
1	2

22. Have you ever had an HIV test?

Yes	No	No response
1	2	3

→ **Go to 26** ←

23. How long ago did you have your most recent HIV test?

Less than a year ago	1
Between 1-2 years ago	2
Between 2-3 years ago	3
Between 3-4 years ago	4
Between 4-5 years ago	5
5 or more years ago	6

24. Have you been told/informed of the result of your most recent test?

Please note that you should not tell me about the actual result. I am only interested whether you have been told/informed of the result of the test.

Yes	No
1	2

25 What motivated you to get tested for HIV?

1 = Community volunteer from TCE	1
2 = Volunteer from the Local NGO	2
3 = Community worker linked to a Government project	3
4 = Doctor from a clinic or public hospital	4
5 = Doctor from a private clinic or hospital	5

6 = Traditional healer	6
7 = Other (specify):	7

D. CONTROL OF THE EPIDEMIC

The next questions ask your opinions about your sense of control of the epidemic

Control and compliance issues	Strongly Agree	Agree	Disagree	Strongly Disagree
26. Know all about it I have thorough knowledge of the HIV virus, how it works and spreads, and the AIDS disease				
27. Know how to avoid being infected I have general knowledge of sexual life, sexually transmitted diseases, the strategy for abstinence, the use of condoms, abuse of children and the eventual risk for myself for this				
28. Decide about yourself I have decided never to get infected by HIV and I have specified how to act so it cannot possibly happen				
29. First sexual encounter I have decided consciously about my first sexual encounter, either to postpone it or to manage it so I do not get infected				
30. Be part of the TCE movement I participate actively in the TCE movement, caring for the sick, helping orphans, campaigning or other activities				

E. ACTIVE INVOLVEMENT IN HIV/AIDS PREVENTION, TREATMENT AND CARE

The next questions are only for people who have been exposed to the TCE campaign

	Strongly Agree	Agree	Disagree	Strongly Disagree
31. I can take control of HIV/AIDS				
32. The systematic approach of TCE has had an impact on my behaviour and practices				
33. TCE has made lasting changes to my life in relation to HIV/AIDS				
34. TCE campaign was accepted in the community				
35. TCE was helpful to the people on HIV/AIDS				
36. TCE has increased our resolve to know our HIV status				
37. The one-to-one approach has helped us to have total Control of the epidemic.				
38. The mobilization by TCE Field Officers has had a significant impact on the number of people who got tested for HIV				



APPENDIX D: KEY INFORMANT INTERVIEW GUIDE

The semi-structured questions that will be used for the key informant interviews.

A. Type and nature of HIV programme

1. What is/are the target population(s) for the TCE programme?
2. Is there a monitoring and evaluation plan for the programme?
3. Does the programme incorporate faith-based beliefs?
4. Does the programme address fear, stigma & discrimination?
5. Does the programme address issues of sexuality and gender?
6. Does the programme address HIV risk reduction?
7. Does the programme include peer education approach?

B. Interventions for TCE compliance and programme reach

1. Interventions to ensure people know all about HIV and AIDS

What interventions do you have to ensure people have thorough knowledge of the HIV virus, how it works and spreads and the AIDS disease?

2. Interventions to increase knowledge of how to avoid being infected

What interventions do you have to increase general knowledge of sexual life, sexually transmitted diseases, abstinence, the use of condoms, sexual abuse of children and the eventual risk for people for this?

3. Interventions to empower people to decide about themselves

What interventions do you have to empower people to decide never to get infected by HIV and to concretely specify how to act so it cannot possibly happen?

4. Interventions to delay first sexual encounter

What interventions do you have to empower people to decide consciously about their first sexual encounter, either to postpone it or to manage it so they do not get infected?

5. Ways to encourage people to be part of the TCE movement

What ways are you using to encourage people to participate actively in the TCE movement, caring for the sick, helping orphans, campaigning or other activities?

6. What strategies do you use to mobilize people to know their HIV status?

7. What strategies do you use to mobilize people to become “*passionates*” (or community activists)?

8. What is your plan for reaching schools, workplaces, churches and traditional healers in the TCE site?



APPENDIX E: DRAFT RECORDS REVIEW FORM

A. Basic data

Reporting period:
 Project title: Total Comparison of the Epidemic (TCE)
 Location of project:
 Date started:
 Completion date:
 Report prepared by:
 Implementing agencies:
 Funding agency:

B: Evaluation of impact

Major components/ Activities <i>Core indicators</i>	Targets (milestones)	Achieved	Rating of achievements (0-4)	Factors explaining over/under achievement
<i>TCE compliant</i> (they have control).	Over 80%			
People are mobilized know their HIV status	Over 50%			
<i>"Passionates"</i> (community activists)	Over 5% are activists)			
The programs have reached all households	100% of households			
Overall assessment of impact				

Guide to rating:

- 0 = nothing implemented,
- 1 = low (extensive shortcomings),
- 2 = moderate (only partially achieved),
- 3 = satisfactory (largely achieved, despite a few shortcomings),
- 4 = very good (fully achieved-with very few or no shortcomings).

C. Follow up - remedial action

Components/activities	Relevant areas (budget, staffing, organization, etc.)	Remedial action needed to ensure de of output	Responsible agency/person

D. Outcome evaluation

TA= too early to assess, 0=nil, 1=low, 2=moderate, 3=good, 4=very good

Core Outcome Indicators	Performance Rating (0-4) likely is it that the immediate objectives have been realized in time?)	Comments
1.1. Number of lessons and debates in the community on HIV/AIDS. 1.2. Number of volunteers trained in HIV/AIDS who then educate the community. 1.3. Number of volunteers trained to run the HIV/AIDS sessions. 1.4. Number of AIDS campaigns that were conducted in the past year.		
2.1. Number of people mobilized in GTM to play an active role on HIV/AIDS in their community. 2.2. Number of community volunteers trained on HIV/AIDS. 2.3. Number of people in the community educated by volunteers on HIV/AIDS. 2.4. Number of meetings held with councillors and other stakeholders to coordinate HIV/AIDS activities in the community. 2.5. Number of people mobilized by TCE in the community to know their HIV status, by being tested, and receive pre- and post-counselling.		
3.1. Number of HIV/AIDS sessions held to empower people to overcome fear and denial. 3.2. Number of sessions held to reduce stigma attached to HIV/AIDS in the community.		

3.3. Number of HIV positive persons taught to positively		
<p>4.1 Number of families identified and assisted to care for orphans, children in need and families affected by HIV/AIDS.</p> <p>4.2. Number of AIDS Committees organized</p> <p>4.3. Number of bedridden and terminally ill patients provided with home-based care by TCE in the GTM area.</p> <p>4.4. Number of volunteers trained as care givers to carry out cleaning for patients, supervision of treatment, cooking and counselling.</p> <p>4.5. Number of families trained to take over the care of patients.</p>		

E. Summary project evaluation

Evaluation criteria	Performance rating (0-4)
1. <i>EFFICIENCY</i> (How likely is it that <i>TCE programs have reached schools, workplaces, churches and traditional healers in the intercommunity?</i>)	
2. <i>EFFECTIVENESS</i> (How likely is it that over 50% of people have been mobilized to know their HIV status?)	
3. <i>IMPACT</i> (What is the evidence that <i>over 80% of people are TCE converts</i> (they have taken Comparison?)	
4. <i>SUSTAINABILITY</i> (How likely is it that <i>over 5% are active as "passive community activists?</i>)	

F. Brief assessment of:

- a) Major successes achieved
- b) Problems encountered
- c) Relevant external factors influencing progress/performance
- d) Remedial action taken and prospects for next year.